STATE OF MASSACHUSETTS CHILDREN AND YOUTH FACT BOOK

October, 1998

Prepared by the Massachusetts Legislative Children's Caucus

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EXECUTIVE SUMMARY

The State of Massachusetts Children and Youth Fact Book has become an autumn tradition for the Children's Caucus, and this 1998 edition marks the eighth annual publication. The actual growth of the document, which began as a two page fact sheet, is perhaps most noticeable, but the depth of the analysis within these pages has also expanded. Diverse statistics and analysis have been pulled from a wide range of research to present a comprehensive view of the status of children, both in the Commonwealth and in the United States as a whole. This fact book serves to inform us about the lives of children, youth and families in Massachusetts, and about their well-being within a national context.

Perusing the book's table of contents forces the reader to see the wide range of issues of health, well-being and behavior which the young people of the Commonwealth face each day. The topics discussed reflect the maturation of a child: from birth data to child care, from education to juvenile justice. At each stage, all children and families, particularly some of the most vulnerable residents, face a range of challenges.

The statistics might encourage, sadden or educate us. This book attempts to show that these numbers signify actual people making their way through life. For example, the waiting list for income-eligible child care was 12,203 as of May 1998. The FY98 and FY99 budget increases for this program have allowed more families to get quality, subsidized child care; however this statistic shows that many real children and families still wait.

In many areas of child and youth health and well-being, Massachusetts can be very proud and optimistic. For example, the Commonwealth was ranked the best state in the nation for immunization of children 2 years and under by the National Immunization Survey. This shows that the state recognizes the fiscal and effective benefits of this preventive program, and has set the standard for the country. In addition, the Massachusetts rate of adolescents giving birth is about half the national rate and reflects the statewide efforts to prevent teen pregnancy.

Both the areas of strength and weakness in the Commonwealth must move us forward for the children of Massachusetts. The successful achievements show what can work for young people and families, and the areas of continued challenge inspire us to continue working for the youth of the state.

Here are some of the new topics about the well-being of children in the Commonwealth which are included in this year's fact book.

PERMANENCY

This year's fact book has expanded on the past analysis of adoption statistics to include guardianship. This change reflects the fact that a permanent stable home, the goal for children in the substitute care system, can come in various legal forms. In fiscal year 1997, the Department of Social Services finalized 1,191 adoptions in Massachusetts, the highest number of adopted children in DSS history, and 615 guardianships. However there are approximately 3,545 children who are still waiting for a stable, safe family.

FAMILY LITERACY

Family Literacy is an education model which addresses the strengths and needs of both parents and their children because the literacy rates of adults impact greatly on the reading proficiency and personal development of their children. Children in 114,000 families in the Commonwealth have a parent who cannot read aloud to them, and an additional 264,000 families have parents who have difficulty helping their children with homework.

HEALTH INSURANCE EXPANSION

Massachusetts has been a leader in health insurance expansions for children which have inspired federal legislation. The fact book includes an analysis of the various types of coverage and expansions at the state and federal levels.

GAY, LESBIAN AND BISEXUAL YOUTH

The Commonwealth has also been in the forefront in recognizing the civil rights and unique challenges of gay, lesbian and bisexual youth. The Massachusetts Governor's Commission on Gay and Lesbian Youth was the first of its kind in the nation, and the landmark Gay and Lesbian Rights law also offered full legal protection to gay teenagers.

These new topics, and many more subjects in this book, serve to educate and encourage us. This analysis of the well-being of the state's youngest citizens show that Massachusetts is in the forefront in many matters of public policy, and it also suggests that the work for children must proceed.

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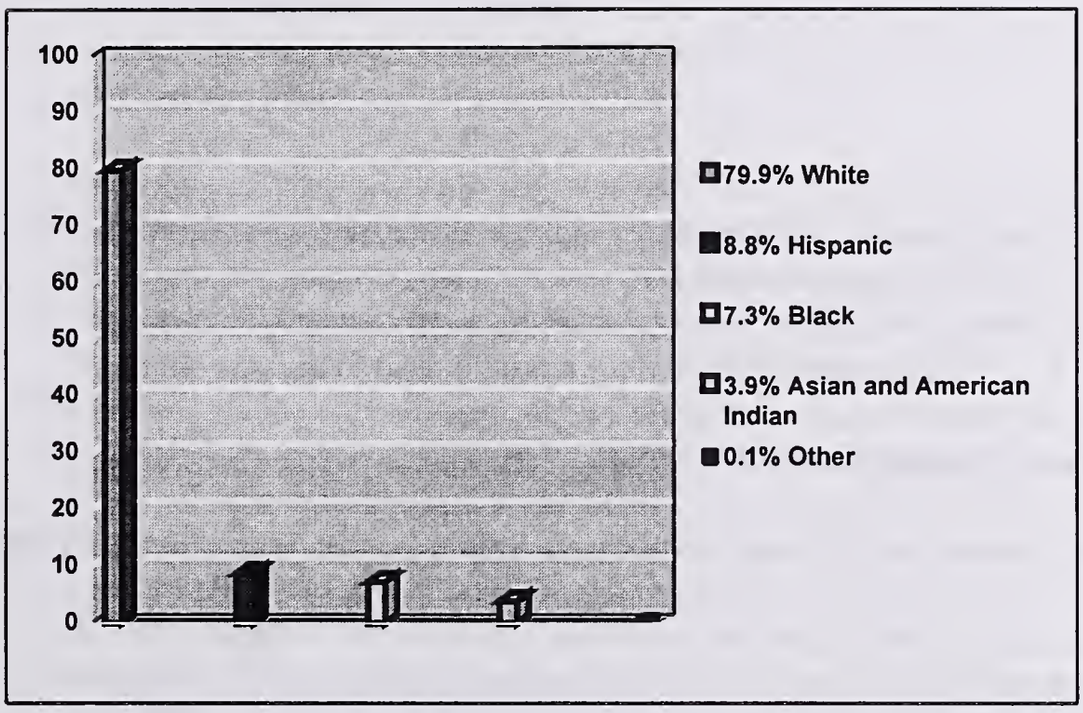
I. DEMOGRAPHICS

A. POPULATION

In Massachusetts, there are 1,553,149 children and youth under the age of 19, representing 25.3% of the total population in the Commonwealth. Of these children approximately:

- 79.9% are White
- 8.8% are Hispanic
- 7.3% are Black, non-Hispanic
- 3.9% are Asian and American Indian [1]

MASSACHUSETTS CHILD POPULATION BY RACE



In the Commonwealth, there are 476,241 children under age six, and an additional 945,688 youth are between 6-17 years of age.

There are 69,048,323 children and youth under the age of 18 in the United States. [2]

B. BIRTHRATE

In 1995, 80,164 live births occurred in Massachusetts, a 10% increase since 1980, but a 13% decrease since 1990.

- 77.0% of births were to white, non-Hispanic women
- 9.9% of births were to Hispanic women
- 7.2% of births were to black non-Hispanic women
- 4.2% of births were to Asian women

In 1996, the birth rate was 55.6 births for every 1,000 Massahusetts women 15-44 years old. This was 15% below the national birth rate of 65.7 births per 1,000 women ages 15-44. [3]

In 1996, there were approximately 6,000 multiple births (in sets of three, four or more) nationwide, an unprecedented number and a 19% jump from 1995. The dramatic growth is largely explained by the increased use of fertility treatments, but the rise in multiple births has also contributed to an increase in low birthweight babies. [4]

C. POVERTY

In 1995, 17.2% of Massachusetts children under 18 lived in families with incomes below the Federal Poverty level, ranked twentieth nationwide. [5] 6% of poor children in the Commonwealth are living in extreme poverty, where the family income level is 50% of the poverty level. [6] The National Center for Children in Poverty found that another 29.9% of Massachusetts children are living close to the poverty line, which, for a family of four, is an estimated annual income of $16,400.

At a national level, poverty in the lives of America's children continues to grow. The rate of poor children in the United States increased from 14.4% in 1973 to 20.5% of all children in the country by 1996. The gap between the poorest and wealthiest families also continues to expand: the poorest one fifth of families had incomes 9% lower than in 1973, and the family incomes among the wealthiest one fifth increased by 35%. [7]

D. TAFDC (TRANSITIONAL ASSISTANCE TO FAMILIES WITH DEPENDENT CHILDREN)

In FY98, there were approximately 130,000 children on the TAFDC rolls in Massachusetts.

As of July 1998, there were 62,394 families in the Commonwealth on TAFDC. The Department has reported that there has been approximately a 42% decrease in the welfare caseload since 5 years ago. There are 161,724 total TAFDC recipients, with 94.5% female heads of household. In Massachusetts, the average family receiving TAFDC is comprised of a mother and two children. The TAFDC recipients are 45.85% white, 29.74% Hispanic, 18.5% black, and 5.8% from other races.

The educational background of the TAFDC heads of household is varied:

- 2.76% have had no schooling
- 10.84% have completed 1-8 years of school
- 33.27% have completed 9-11 years of school
- 8.77% have a GED
- 31.48% have a high school diploma
- 8.85% have completed some college studies
- 2.64% have completed 2 years of college
- 1.39% have completed 4 years of college [8]

The average annual grant for a family of three living in private housing is $6,948, including a $40/ per month rent subsidy. The average annual grant for a family of three who is subject to the work requirement is 2.75% less per month, $6,780. A family of three in public housing would not receive the rent subsidy. [9]

The Department of Transitional Assistance has reviewed the closed cases of former welfare recipients and has found that 52% were working in paid jobs. More than 25% of families had their cases closed because they had other means of financial support, or had moved out of Massachusetts. An additional 8% no longer had children eligible for TAFDC. The other 13% were closed for a variety of reasons. [10]

Minority TAFDC recipients have had a more difficult time moving from welfare to the job market. The caseload has dropped 52% for whites, 41% for blacks and 34% for Hispanics. Critics point to the challenges of job opportunities and transportation for welfare recipients who live in poorer, urban areas. [11]

On December 1, 1998, the first round of welfare recipients in the Commonwealth will lose their TAFDC benefits, under the state's two year time limit instituted by the 1995 Massachusetts welfare reform act, in contrast to the 60 month limit that was included in the federal legislation. Two-thirds of states use a five-year time limit, including some states which terminate benefits to adults, but not to children, and others have no time limit at all. In Massachusetts, the terminated family is then ineligible for aid within a 5 year period. The termination of TAFDC benefits will be monitored by the Department of Public Health. [12]

There are some families which are exempt from the time limits, including families where the child of record is under two, and families whose head of household is disabled, pregnant and within 120 days of her due date, aged 60 or older, or a teen parent under twenty complying with TAFDC requirements. Homeless families are not exempt, and a recent study showed that 54% of Massachusetts homeless families surveyed would be affected by the time limit. [13]

E. SUPPLEMENTAL SECURITY INCOME (SSI)

Supplemental Security Income (SSI) is the cash assistance program for children with disabilities in low-income families that was an extension of the Social Security Act. [14] As of November 1997, there were 16,580 Massachusetts children receiving SSI.

A total of 2,240 cases were terminated in the Commonwealth between August 1996 and December 1997. [15] The 1996 federal welfare law enacted more stringent standards about SSI qualification for poor children. Case reviews were undertaken to evaluate children under the new requirements, and more than half of the recipients in the reviewed cases were denied benefits. More than 82% of the children nationwide who have been denied continued assistance have mental disorders, including retardation, emotional and learning disabilities. [16]

II. HOMELESSNESS

A Massachusetts Department of Education survey found that an estimated 4,929 children and youth between kindergarten and twelfth grade are homeless in the Commonwealth. 2,746 of these young people are enrolled in public school, but only 495 were reported to be regularly attending school. An additional 1,711 preschool-age children are estimated to be homeless in Massachusetts. [17]

Emergency Assistance (EA), which is a state/federal program operated by the DTA, was founded to prevent homelessness, as well as to provide shelter to families who are deemed homeless and income eligible. Many EA benefits have been eliminated, including disaster benefits, security deposit guarantee and moving expenses. In addition, the narrower definition of homelessness excludes families who are "doubled up" or at immediate risk of being homeless. [18]

Research has shown that the instability associated with homelessness results in more danger of these children being subject to educational, emotional, behavioral, and/or developmental problems and delays. 66.7% of homeless children suffer from a chronic health condition, and one-third of homeless students repeat at least one grade in school. [19]

III. HOUSING

The U.S. Department of Housing and Urban Development considers housing affordable if it consumes less than 30% of family income. About 3 out of 4 poor families nationwide spend more than 30% for housing. More than one third of very low income families spend over 70% of their income for rent. [20]

In Massachusetts, many families, including working poor and two-parent families, must meet their housing needs in an environment of rapidly decreasing government supports. 1997 marked the first year since 1974 that tenant based rental assistance was not available to families, and state level assistance has not been provided since 1990. Meanwhile, average private market rents are over $850 per month.[21]

The average cost of a home in Massachusetts is $186,549. [22] Almost 59,000 homeowner households pay over half their income for housing, including 42,000 "extremely low income" homeowners. [23]

The conditions within households in the United States are also hazardous to children and families. Over 1.2 million families nationwide live in housing with severe or moderate physical problems. Research has shown that inadequate housing dramatically increases the incidence of asthma, respiratory disease, injuries, and lead poisoining. [24]

IV. HUNGER

Project Bread estimates that 62,000 children under age 12 in Massachusetts are hungry, and that another 151,000 children are at risk of being hungry. Thus, as many as one in five children in Massachusetts is likely to be hungry. [25]

In Massachusetts during fiscal year 1997, approximately 190,000 children participated in the food stamp program. [26] The food stamp component of the federal welfare legislation will cut benefits by $528 million over the next six years. The impact on families will be a 20% reduction in food stamp benefits, which is the equivalent of reducing the average per person per meal benefit from 80 to 66 cents. These cuts will largely be absorbed by the youngest citizens and the poorest families. An estimated half of food stamp recipients are children, both state-wide and nationally, and fully half of foodstamp cuts will impact families at below half the federal poverty line (fpl). The monthly income of a family of three at half fpl would be approximately $548.

Many families in the Commonwealth struggle to balance their expenses, even with a basic need like food. One sign that there is great nutritional need is that the food pantries and soup kitchens funded by Project Bread served over 17 million emergency meals last

year. Particular seasons have added challenges for families, such as the high cost of heating bills in the winter and the lack of school meals during the summer. [27]

The Supplemental Food Program for Women, Infants and Children (WIC) is a nutrition supplement program which supplies coupons for a specific list of vitamin and mineral rich food, as well as provides access to health care and nutrition information. There were 118,819 women, infants and children in Massachusetts who participated in WIC in FY97.

The General Accounting Office estimates that every dollar spent on WIC saves $3.50 in Special Education and Medicaid expenditures. In 1996, Congress rejected the request for further financial growth of the program for WIC for the first time since the successful program was established in 1972.

The School Lunch and Breakfast Programs provide free and reduced lunches to low income school children. In the 1997-98 school year, 255,698 Massachusetts public school children were enrolled in the free or reduced-priced lunch program. An average of 80% of eligible children statewide received the free lunches.

There were 219,985 public school children were enrolled in the Massachusetts School Breakfast program in the 1997-98 school year. However, the participation rate of eligible children receiving free breakfast was only 39.5% for children. The Massachusetts FY99 budget includes two new line-items to fund pilot programs to increase participation in the school breakfast program. Research has shown a correlation between the school breakfast program and fewer problems with tardiness, absense, depression, anxiety and hyperactivity. [28]

The Summer Food Program serves to partially fill the gap caused by the absense of school meals for low income children, during school vacation. The Summer Food Service Program (SFSP) served 39,707 children in the Commonwealth in FY97. [29]

Research has shown that even mild forms of undernutrition and hunger can cause adverse effects in children, including iron deficiency anemia, difficulties with learning and cognitive development, fatigue and stunted growth. [30] Children in families that experience hunger are nine times more likely to experience unwanted weight loss, five times more likely to experience fatigue, twice as likely to suffer frequent colds, four times more likely to experience problems with concentration, and four times more likely to be absent from school than children in non-hungry, low-income families. [31]

V. CHILD CARE

As of late August 1998, there were 198,435 full-time child care slots, licensed by the Office of Child Care Services (OCCS), in Massachusetts.

The child care providers consist of:

- 61,131 family day care slots from 11,007 programs
- 32,631 school-age child care slots from 726 programs
- 104,673 group day care slots from 2,218 programs. [32]

Another category of child care is in-home care, such as nanny, au pair or kinship caregiving. This is a legal form of care that is not subject to state licensing or training requirements. [33]

The need for child care in the Commonwealth has grown as the number of working parents, particularly working, single mothers, has steadily risen. An estimated 60% of Massachusetts children, approximately 247,700, have working parents. [34]

Many working families face the challenge of securing affordable, available, quality child care in the Commonwealth. Center based child care for a four-year-old costs an average of $7,119 and about $9,854 for a one-year-old. For example, two parents working full-time in minimum wage jobs would pay 79% of their yearly income ($21,400 before taxes) on child care for their infant and preschooler. [35]

A wide range of state assistance serves to help a complex range of families to meet their child care needs, including:

- Income-eligible child care, in the form of contracted slots and vouchers, is made available to low income working families whose family income is less than 50% of the state median income. The waiting list for working families who need income-eligible child care was 12,203 as of May 1998, marking a decrease of over 1,000 from February. There is FY99 funding for approximately 11,800 contracted slots, 4,600 vouchers and an additional 8,000 vouchers for former TAFDC recipients who have been off the rolls for over a year.
- Informal child care is available for low income families, or families on TAFDC who are in approved education and/or training programs. There is informal child care reimbursement for up to $15 per day for child care by relatives, neighbors or friends. OCCS presently has funding for 5,400 informal slots in FY99.
- Employment services child care (ESP) is provided for TAFDC recipients in the employment services program, and to former TAFDC recipients after their benefits are terminated due to employment.

- Teen Parent Child Care is available for teenagers who are TAFDC recipients attending high school, SSI recipients in education, work or training activities, and low income teenagers who are at risk of being TAFDC eligible. [36]

Several child care programs in the Commonwealth respond to specific needs. Supportive child care slots are available to families in the protective service system, and the program includes comprehensive services as part of a DSS treatment plan. Trial Court Child Care provides licensed, drop-in child care and support services to families involved in the criminal justice system. The program has been instituted in eight Massachusetts court systems to protect children, to improve efficiency of the courts, and to link court-linked families to community services. Approximately 7,400 children in Massachusetts were enrolled in fiscal year 1998. [37]

The quality of the child care system is crucial to the safety, well-being and healthy development of the state's children. For example, one key concern is that child care facilities need to be safe and suitable. A 1994 study found that about 60% of child care facilities in Boston were not originally designed for child care. [38]

The stability and quality of child care providers is also crucial. In 1997, Massachusetts was one of only nine states that met recommended levels for the number of children a single caregiver could care for in a child care center. These regulated ratios protect children and improve the quality of care. However, many advocates are concerned that the high turnover and low salaries in the industry threaten the quality of child care providers. The average salary for a child care worker in the Commonwealth in 1996 was $16,540, and the annual turnover rate for child care teachers is 28%. In addition, professional development can be unavailable or unaffordable, and is not yet linked to career advancement. [39]

The Child Care Resource and Referral Network provides consumer education, child care subsidy management, advocacy, and training services in Massachusetts. Data from the CCR&R network reflects the demand for child care in the Commonwealth. 15,711 families, comprising approximately 20,000 children, accessed child care information from the network in FY97, an increase of more than 10%. Calls from low-income families, earning less than $23,000 annually, increased 40% in FY'97. [40]

Research shows that quality child care can stimulate positive benefits for children, including improvements in language development, improved social skills and self-perception. Developmentally appropriate child care can foster cognitive skills that improve intelligence and creativity. [41] However, other studies have shown that children in *poor* quality child care are delayed in language and reading skills, and display more aggressive behavior. [42]

VI. HEAD START

Head Start, the federal preschool education and early childhood development program, enrolled 11,247 Massachusetts children in 1997. The comprehensive nature of the program is reflected in the statewide rates of 97% of Head Start children who are medically cleared and immunized, and an additional 92% who have completed dental exams. The family involvement component can be observed in the 9,619 Massachusetts parents who volunteered in the programs, and in the fact that 33% of staff were former Head Start parents. The program has adapted to the changing social needs of children and families by increasing the number of full year, full day slots by 50%. [43]

Since its inception, more than 17 million children in the country have been in the Head Start program. [44]

VII. SCHOOL-AGE CARE

78% of mothers with children between the ages of six and seventeen work in the Commonwealth. These school-age children often find themselves without adult supervision in the hours before school, as well as in the time period between the close of school and the end of the workday.

Families of children throughout this age range have limited choices in the search for care and activities, as only one in four public schools in Massachusetts in 1994 offered extended day programs. In FY97 there were 40,199 school-age child care slots, in school-based and community based programs, to serve children ages 5-12 during out of school hours, with a 7% vacancy rate.

The shortage of after school activities is a significant challenge for the estimated 75,000 Massachusetts school-age children who live in families with incomes below the poverty line. [45] Nationwide, only one-third of schools in low-income neighborhoods offered after school programs. [46]

Research has shown that this is a vulnerable time of day for children and youth. 57% of juvenile crime occurs on school days, and one in five juvenile crimes are committed between the hours of two and six o'clock in the evening. [47] Another study revealed that eighth graders who are left unsupervised after school are at greater risk of tobacco, drug and alcohol abuse than those in a supervised setting. [48]

VIII. PERMANENCY

A. ADOPTION

Chapter 303 of the Acts of 1992 instituted major changes to Chapter 119 (Care and Protection statute) and Chapter 210 (Parental Rights and Adoption statute) to help reduce the length of time children in the substitute care system must wait for permanency. The law allowed for the termination of parental rights (tpr) in a Care and Protection proceeding, establishes a time frame for adjudication of Care and Protection cases, and sets forth factors in consideration of parental fitness.

In fiscal year 1997, the Department of Social Services finalized 1,191 adoptions in Massachusetts. Though this is the highest number of adopted children in DSS history, it was partially offset by 1,050 children entering the adoption system. In FY97, children leaving DSS placement for adoption had spent a median of 3.5 years in substitute care.

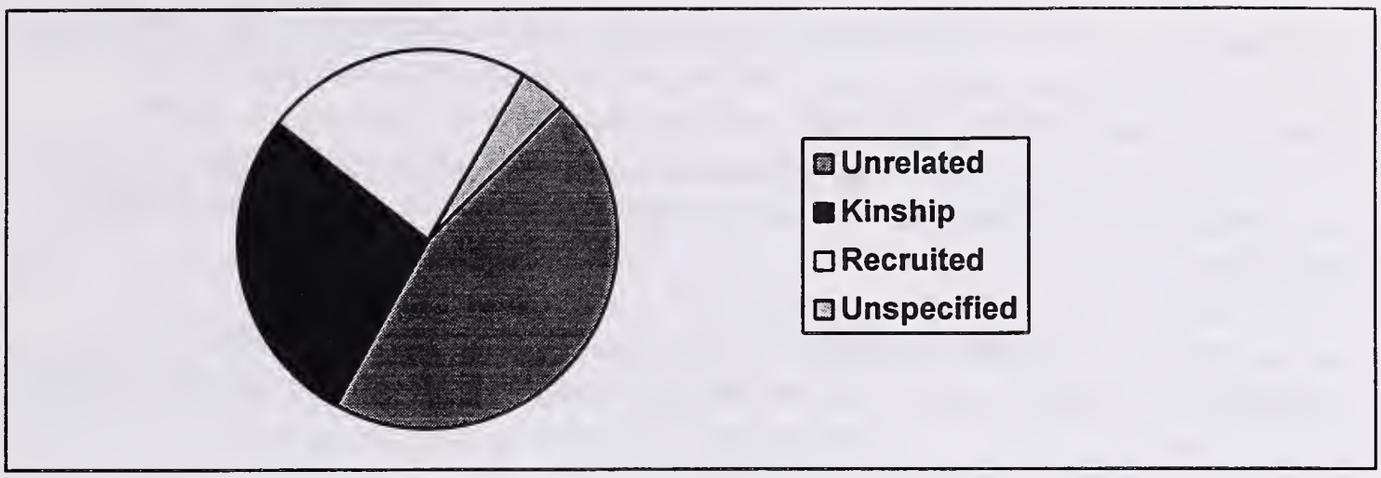
The statewide adoption rates for white, black and Hispanic children who are in the system with the service plan goal of adoption were 31%, 27% and 25% respectively. The most common ages of the adopted children were between 2 and 7 years. Adolescents accounted for 8% of all adoptions.

It is the goal of DSS to keep sibling groups, or parts of sibling groups, together in the adoption process. The total number of adoptions in FY97 comprised 265 sibling groups. In 75% of the groups, all the siblings were adopted by a single family. In 37 sibling groups, each child was adopted by a different family.

64% of the children were adopted by married couples, while 16% and 14% were adopted by a parent who has never married or is divorced respectively. 43% of the adoptive parents were 40-49 years of age, while 31% were in the range of 30-39 years of age.

The types of adoptive homes where these 1,191 children were placed in fiscal year 1997 were:

- 46% Unrelated, who had been the Foster Parents
- 27% Kinship Adoptions
- 23% Recruited Adoptive Family
- 4% Unspecified



B. GUARDIANSHIP

Guardianship is a permanent plan designed to provide a stable environment to children who cannot be returned home or adopted, for a variety of reasons. The children in the program must be at least 12 years old, or must be part of a sibling group where one child is at least 12 years old. There are exceptions made to the age policy, as well as to other rules about guardianship; for example, there is no age requirement for children who reside with relatives for guardianship.

During FY97, 615 guardianships were finalized in Massachusetts, the highest number of guardianships granted since the program began in 1984. There was a 46% increase in guardianships from FY94 to FY95. 70% of children who received guardianships were under 12 years old, because they were with relatives or part of sibling groups.

Prior to the granting of guardianship, children who received guardianships during FY97 had spent a median time of 2.2 years from their most recent entry into placement. 54% of guardianship children were in placement for more than two years, a decrease of 7% from FY96. [49]

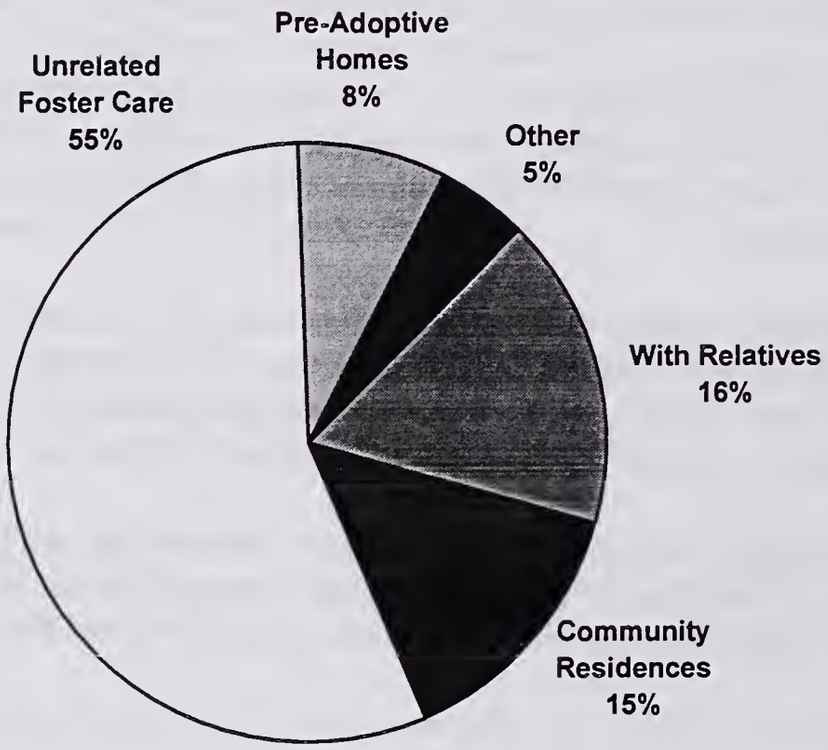
C. FOSTER CARE

As of July 1997, DSS reported that there were 11,957 children in substitute care who were less than 18 years old, a decline of 4% since 1996 and the second annual decrease after 11 years of growth in population. 79% of children in placement were in foster homes (unrelated, related and pre-adoptive), a total of 9,493 foster children statewide. An additional 15% of the children in substitute care lived in community residences. The remaining children were in shelters, hospitals, "on the run" or in other locations.

In Massachusetts, 42% of the children in placement were adolescents (12 to 17 years old), and 52% of adolescents were female. The proportion of adolescents in placement increased 2% from 1996 to 1997, after declining from 54% in 1985 to 39% in 1995. 1997 marked the first year since 1990 where the number of adolescents in unrelated foster homes was higher than the number of children under 5 years old who were in unrelated foster homes.

The median age of children in substitute care was 10.2 years, and the median time in continuous care was 1.4 years. Children in pre-adoptive homes had been in placement for an average of 3.3 years.

The distribution of the most common placement locations of consumers in the DSS system are as follows:



Among the 9,493 children under 18 in the foster care system,

- 4,724 were white
- 2,140 were black
- 1,839 were Hispanic
- 790 were another race or race was unspecified [50]

VIII. CHILD SUPPORT

The Massachusetts Department of Revenue collected a record $282 million in child support collections in fiscal year 1998. This is an increase of over $11 million from FY97. There was also a 16% increase in the "direct pay" category, from $44.6 million in FY97 to $52 million in FY98. Many believe that the rise in this difficult category, where the parent pays directly rather than by withdrawal from wages, reflects the increased visibility of child support enforcement techniques in the Commonwealth. There has also been a 5% increase in voluntary paternity acknowledgments.

In FY98, DOR's Individual Case Enforcement Team (ICE) arrested 60 child support delinquents on both criminal and civil warrants. In addition, the ICE Seizure program, which began three years ago, seized 26 cars, trucks and properties from delinquent parents, totalling $109,729.

The DOR Child Support Enforcement Unit has various programs to encourage involvement and parental obligation. This year marked the second annual Father Recognition Contest which awarded grand prizes to sixteen out of 4,700 noncustodial parents who consistently pay child support, chosen from tributes written and drawn by the fathers' own children. In addition, there was a new program instituted which sent "Happy Birthday" reminders to parents who had not made payment in the last six months, around the birthdays of their children. The focus of the personal letter was to encourage the noncustodial parent to help meet the individual child's needs. [51]

Nationwide in 1992, 11.5 million parents were raising children with an absent parent, and only 54% had child support orders. Of these 5.3 million parents with awarded and due child support orders, only half received the full amount due and a quarter received no payment at all. [52]

The results of a longitudinal study show that after divorce, mothers face more dramatic income shifts than fathers. After separation, the poverty rate shifts for mothers from 11 percent to approximately 38 percent, but for fathers after separation, the poverty rate remains largely unchanged. Among mothers who receive child support payments, the poverty rate fell from 39% to 27%. There was a slight increase in the poverty rates of the nonresident fathers paying child support, from 9 to 12 percent. [53]

IX. EDUCATION

A. STUDENT ENROLLMENT

In Massachusetts, there were 1,079,555 students enrolled in Massachusetts public and private schools (Pre-Kindergarten to Twelfth Grade) during the 1997-98 school year. There were also about 1,500 students enrolled in Post-Graduation studies. Of the total student population, approximately 88% were enrolled in public schools. [54]

Research has shown that a solid education is a highly reliable avenue to success for children and youth nationwide. College graduates can expect to earn twice the wages of high school graduates and nearly triple the wages of a high school dropout. [55]

B. DROP-OUT RATE

In 1996-97, the annual dropout rate was 3.4%, unchanged from the rate of the previous school year, marking the lowest rate in the last five years. This represents a total of 8,453 students enrolled in grades nine through twelve who dropped out in the 1996-97 school year and did not return by October 1, 1997.

The drop-out rate by gender was 3.9% for males and 3% for females. Males have been at a higher drop-out rate for the past several years.

The racial/ethnic distribution was:

- Hispanic students had a drop-out rate of 8.2
- Native American students had a drop-out rate of 6.0
- African-American students had a drop-out rate of 5.6
- White students had a drop-out rate of 2.7
- Asian students had a drop-out rate of 2.7

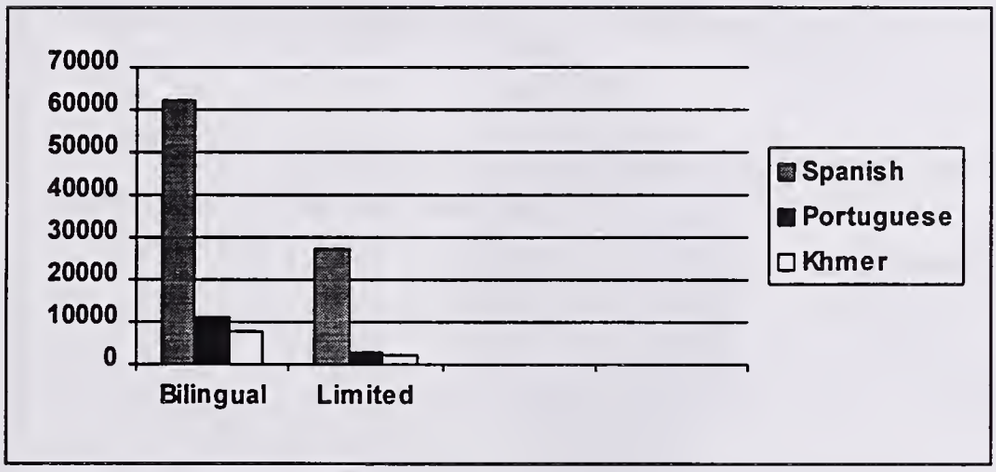
The drop-out rates vary statewide by individual school and by geographic area. 54% of schools had a drop-out rate of 2.5% or less, approximately 5% had a rate higher than 10%. [56]

The percentage of teens who are not attending school and not working grew 17% in the Commonwealth from 1985-1995. Massachusetts was only one of two states to experience an increase during the decade in this area. [57]

C. BILINGUAL EDUCATION

In the 1996-97 school year, there were 119,838 bilingual children and youth in the Massachusetts public schools. There were an additional 45,412 public school students who were classified at a limited English speaking level.

The most common languages among the bilingual students in the Commonwealth were: [58]



D. READING PROFICIENCY

In April, 95% of Massachusetts third graders took the Iowa Basic Skills Reading Test. The 1998 results of this second annual test shows that scores have stayed level with 1997. The third graders in the Commonwealth read as well or better than 64% of their peers nationwide. However, 27% of the students tested could not read at a satisfactory level.

- 21% scored at the "Advanced" level
- 47% scored at the "Proficient" level
- 21% scored at the "Basic" level
- 6% scored at the "Pre-Reading" level [59]

F. FAMILY LITERACY

Family Literacy is an education model which addresses the strengths and needs of both parents and their children. The family literacy model coordinates learning among different generations to maximize social and educational benefits.

The literacy rates of adults impact greatly on the reading proficiency and personal development of their children. The 1995 Adult Education Committee reports that there are approximately 877,000 adults in Massachusetts that have not yet attained functional literacy, and 465,000 of these adults have children under 13. Children in 114,000 families in the Commonwealth have a parent who cannot read aloud to them, and an additional 264,000 families have parents who have difficulty helping their children with homework.

The family literacy model can include parents reading to their children, as well as comprehensive programs, such as Even Start, which improve the family's reading skills inter-generationally. [60]

G. HOME SCHOOLING

There are an estimated 920,000 children nationwide, kindergarten-twelfth grade, who are home schooled. There has been substantial growth in this category, as only 2,500 children in 1978 were home schooled. Even since 1994, the population of home schooled children has grown from 735,000 children and youth. Research has shown that the national rate of 29% dissatisfaction with the nation's public schools has been the biggest reason that home education has grown so dramatically.

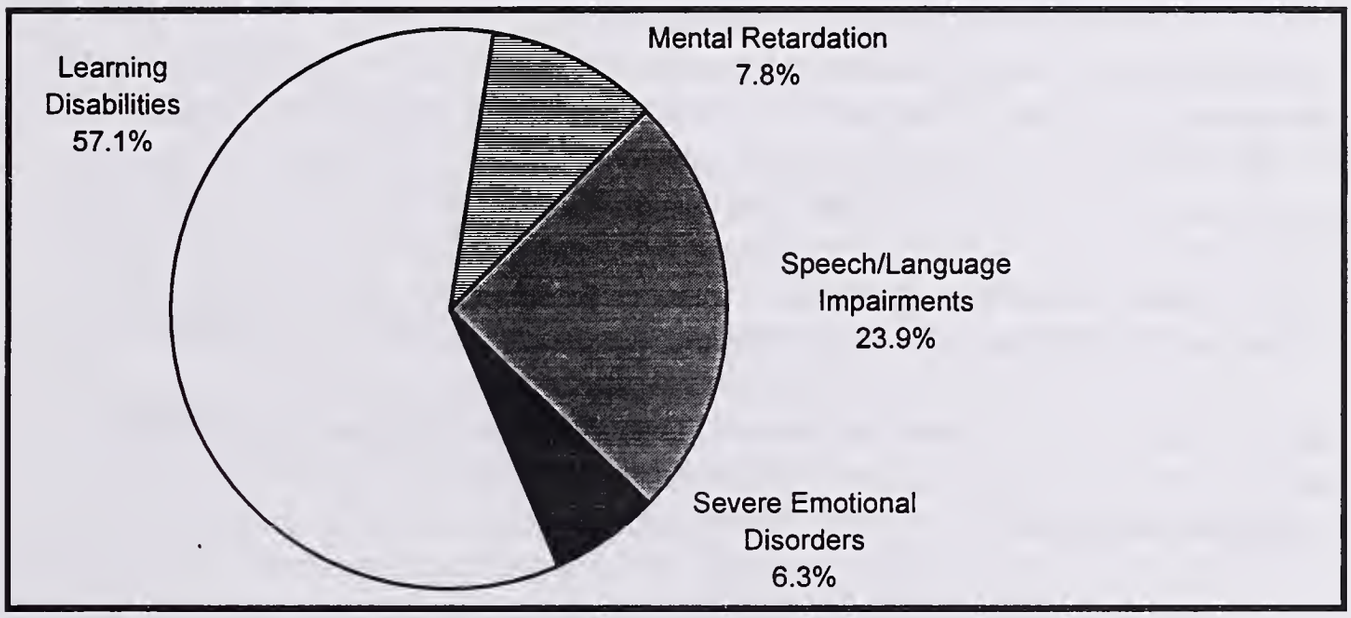
Many critics believe that home schooling is inadequate because it lacks the comprehensive social interaction of the school environment. However, test scores show that home schooled students from all 50 states scored in the seventy-seventh precentile, in contrast to the public school average in the fiftieth percentile.

Home schooling is legal in all 50 states, but regulations vary by state. Massachusetts is considred the most restrictive state in the country in relation to home schooling. In the Commonwealth, the manner of home schooling must be approved in advance by the superintendent or the school committee. School committees may inquire about the educational attainment of the parents or amount of instruction time, may insist on an evaluation plan, and can request access to curriculum. [61]

H. SPECIAL EDUCATION

In the 1996-97 school year, there were 159,042 public school students receiving special education services in Massachusetts, an increase of approximately 4,000 students over the previous year.

The most common disabilities of the special education population as of December 1996 were:



Less than 1% of children receive services in each of these categories: hearing impairments, visual impairments, orthopedic impairments, deaf-blindness, autism, traumatic brain injury, and other health impairments. [62]

Massachusetts ranks fourth in the nation for including students with disabilities in integrated classrooms.

Only 17% of the state's special education costs are covered by the Commonwealth, though the national average of cost-sharing is 50%. [63]

I. DEVELOPMENTAL DISABILITIES

The Massachusetts Department of Public Health estimates that approximately 41,000 children and youth are developmentally disabled.

Developmental disabilities are generally defined as severe, chronic mental and/or physical impairments (i.e. mental retardation, autism, cerebral palsy) that occur at an early age, are likely to continue indefinitely, and have a pervasive effect on an individual's functional abilities and need for services. [64]

The Massachusetts Early Intervention Program (EI) is administered by DPH to provide comprehensive, family focused services for at-risk children in their first three years of life. The children who are targeted for EI services have an "established risk" (developmental disorders), "biological risk" (disorders stemming from events such as prematurity) or "environmental risk" (problems stemming from factors such as parents' chronic illness or substance abuse) In FY98, 18,807 Massachusetts children were enrolled in EI. [65] This number is a jump from the FY97 total of 17,132 children. [66]

Studies indicate that the states may recover, through savings in the costs of special education and institutionalization, between $3 to $7 for each $1 invested in early intervention services. [67]

X. HEALTH

A. HEALTH INSURANCE

There are approximately 108,100 uninsured children in Massachusetts, and an estimated 7.6 million uninsured children nationwide. The Urban Institute estimates the number of uninsured children by utilizing 1994 and 1995 Current Population Survey (CPS) data with adjustment for undercounted Medicaid enrollment. [68]

At the state and federal level, various forms of landmark children's health care expansion attempt to improve this complex public health problem. The Act Providing for Improved Access to Health Care (Chapter 203), which passed in July 1996, increased the state tobacco tax for the Children's and Senior's Health Care Access Fund and expanded two key children's health care programs: MassHealth (Medicaid) and the Children's Medical Security Plan (CMSP). CMSP is a state-funded health insurance program that is administered by the Department of Public Health to provide primary and preventive health care. Children ages 0-18 at any income level, who are not eligible for Mass Health

or not covered by employer based insurance, can participate in the program. Particularly after Mass Health expansion, the fundamental CMSP population will be families between 200-400% of the federal poverty level.

The Children's Health Insurance Program (CHIP or Title XXI), which was passed in August 1997, is the federal program which provides matching funds to states for their health insurance expansion efforts. Massachusetts is eligible for up to $45 million per year in federal reimbursements. In January, Massachusetts filed the proposed CHIP plan with the U.S. Department of Health and Human Services, which was approved in May. Authorization and funding was provided in the FY99 state budget.

In Massachusetts, Chapter 170, which passed in November 1997, acted as the formal authorization of the CHIP expansion and extended Mass Health coverage to children who live in families below 200% of the federal poverty level. The fpl varies by family size, but for example, the monthly income for a family of three at 200% federal poverty level would be $2,275. CMSP benefits were also expanded by Chapter 170, to include eye exams, hearing tests, mental health visits and dental health services.

The Uncompensated (Free) Care Pool is used to cover the costs for certain heath care services at hospitals and health centers for people who do not have insurance or who have no way to pay for health care services. The Pool is funded by hospitals and health insurers, with some assistance from state and federal agencies. [69]

Despite the progressive achievements in health care coverage, private insurance is very difficult to obtain for many working families. The overwhelming majority of uninsured children, 92% nationwide, have parents with jobs. 66% of the nation's uninsured children have at least one parent working full-time all year long. Various challenges face workers who want employer based coverage: including higher premiums, employers who do not offer coverage, and many workers in contract, temporary or part-time work.

A July 1997 National Center for Health Statistics report showed that children without health insurance are six times more likely than privately insured children to go without needed medical care, five times more likely to use an emergency room as a regular source of health care, and four times more likely to have necessary health care delayed. [70]

Consistent pediatric care has been shown to prevent costly health problems and hospitalizations. Children 17 and under, including newborns, comprised 17% of the total hospitalizations in Massachusetts in FY95 and FY96. Children and youth were also responsible for 10% of preventable hospitalizations, the inpatient treatment of conditions for which timely and effective use of primary care should have reduced the risk of hospitalization. [71] Each preventable hospitalization for asthma, bacterial pneumonia, and dehydration averaged $3,061, $4,063, and $2,705 respectively in fiscal year 1995. [72]

B. MEDICAID/MASS HEALTH

MassHealth is the comprehensive title for the Massachusetts Medicaid program, funded by state and federal expenditures. This name was added to the program, which is administered by the Department of Medical Assistance (DMA), to help reduce the stigma felt by clients in a public assistance program. The program, which provides health benefits to low and medium income families, has undergone expansive change after the state legislation changes described above. Many families who had been enrolled in CMSP, or who had been denied MassHealth coverage under the old standards, are now eligible under the expansions in Chapter 170. MassHealth began enrollment of the newly eligible people in the Commonwealth on August 24, 1998.

There are several forms of MassHealth coverage for Massachusetts families under 200% of the federal poverty level (fpl):

- MassHealth Standard offers a full range of health-care benefits to children under 19 who are under 150% fpl (up from 133% fpl), pregnant women under 200% fpl, as well as families with children under 19 and people with a disability which limits or prevents ability to work for at least 12 months, who are under 133% of fpl.
- CommonHealth provides health care benefits to disabled adults, ages 19-64, and children under 19 who do not qualify for MassHealth Standard. Chapter 203 expanded eligibility to CommonHealth participants who cannot work the MassHealth work requirement of 40 hours/month, but they must pay a one-time deductible. Inpatient, outpatient, medical, mental health, transportation services, as well as well-child screenings, are covered by this plan.
- MassHealth Family Assistance provides comprehensive coverage to children under 18 who are not eligible for the programs described above. To be eligible, these children's families cannot have access to employer-based health plans, and family income must be between 150-200% fpl. Although families are not responsbile for co-pays or deductibles, there is a premium of $10 per child per month, with a $30 per month family cap.

  There is also a premium assistance component which provides premium subsidies for children under 18 of families who are between 150-200% fpl and who are enrolled in employer-based health plans. Most recipients will pay the $10 per child per month premium, with the $30 per month cap. However, if the health insurance plan is expensive or if the employer only pays a small percentage, families may need to pay higher premiums.
- MassHealth Basic is a managed care coverage plan for uninsured residents under age 65 who are long-term unemployed, or for residents who have been working but not enough to collect unemployment. Families in these categories, whose monthly income is under 133% of fpl, are eligible for the program. Basic includes

comprehensive services, but it does not include eyeglasses, hearing aids, hospice, adult day care or transportation.

- Health Insurance Premium Payment (HIPP) program provides assistance to individuals or families below 150% fpl who receive MassHealth Standard or CommonHealth to help pay the cost of private health insurance.
  Children below 150% fpl receive additional health benefits, such as eyeglasses or prescription drugs, from Mass Health if private insurance does not provide the services.

C. PRENATAL CARE

In 1996, 80.2% of women received adequate prenatal care in Massachusetts, a 4% decrease from 1995. However, the classification determinations have been made more strident. For a woman to be categorized as "adequate", she must have begun prenatal care during her first trimester, and must have received at least nine prenatal care visits (assuming a full term delivery).

The racial and ethnic breakdown of mothers receiving adequate prenatal care was:

- 83.9% White, non-Hispanic
- 72.6% Asian
- 66.4% Black, non-Hispanic
- 65.9% Hispanic

Within the overall percentage of Asian mothers receiving adequate prenatal care, Cambodian mothers had the lowest rate, at 47.1%.

Statewide, 83.9% of women began receiving prenatal care during the first three months of pregnancy, 2.1% more than the national figure.

Of the Massachusetts women who received adequate prenatal care, only 5.9% delivered low birthweight babies, while 10.1% of women who received late or no prenatal care delivered low birthweight babies.

The adequacy of prenatal care is reflective of maternal age and other selected behaviors. 55.5% of mothers under the age of 18 received adequate prenatal care, while 85.2% of women 35 and older in Massachusetts received adequate prenatal care. 63.6% of women over 20 who had fewer than 12 years of schooling had adequate prenatal care. However, some categories were slightly higher than the statewide average of 80.2%, including first-time mothers and mothers who reported that they were planning to breastfeed.

In 1996, 68% of all Massachusetts women had their prenatal care paid for by private insurers, and 24.3% had their prenatal care covered by public entitlement programs, such as Medicaid or Healthy Start. [74]

For every $1 invested in prenatal care, more than $3 are saved in averted costs of caring for high risk infants. [75]

D. LOW BIRTHWEIGHT

In 1996, 6.4% of Massachusetts births, or 5,105 infants, were born at low birthweight, less than 2500 grams or 5.5 pounds. The state figure is 14% below the national low birthweight figure.

In 1996 in Massachusetts,

- 11.6% of Black, non-Hispanic mothers had low-birthweight babies
- 7.9% of Hispanic mothers had low-birthweight babies
- 6.6% of Asian mothers had low-birthweight babies
- 5.7% of White, non-Hispanic mothers had low-birthweight babies

The highest percentage of low birthweight babies were born to mothers under age 20 and over age 35. There was also a higher percentage of low birthweight babies born to mothers who smoke, 10.6% in comparison to 5.8% of non-smoking mothers.

1.2% of infants born in Massachusetts in 1996 were very low birthweight, less than 1500 grams or 3.3 pounds. The rate of very low birthweight infants was the highest for Black, non-Hispanic mothers, 3.0%.

Babies born with low birthweight are at a greater risk of death, long-term illness, or disability than infants of normal birthweight. The infants are low-birthweight for a variety of reasons: some are premature births, some are full-term but small, and some are both premature and small. [76]

E. INFANT MORTALITY

In 1996, there were 403 deaths of infants less than one year of age, an infant mortality rate (IMR) of 5.0 deaths per 1,000 live births in Massachusetts. This is the lowest rate ever recorded in the Commonwealth. The Massachusetts IMR is 31% below the 1996 prelimiary national rate of 7.2.

In Massachusetts, the neonatal (less than 28 days old) mortality rate is 3.6 deaths per 1,000 live births. The post neonatal (between 28 and 365 days old) mortality rate was 1.4 deaths per 1,000 live births. Though the overall decline from 1995 is extremely small, the post neonatal mortality rate nearly doubled, from 2.6 in 1995 to 5.3 in 1996.

The causes of infant death in Massachusetts in 1996 were:

- 219 deaths, from conditions arising in the perinatal period
- 73 deaths, from congenital anomalies
- 40 deaths from sudden infant death syndrome (SIDS)
- 3 homicides

Though there were 7 more SIDS deaths than in 1995, it is still a substantial decrease from 1994 (58 deaths) and 1993 (62 deaths).

In Massachusetts, the IMR for black infants is more than twice as high as the IMR for white infants. [77]

In the United States, about two-thirds of infant deaths occur in the neonatal period (within the first month after birth), and are due mostly to health problems of the infant or the pregnancy. The other one-third of deaths, in the post neonatal period (after the first month of life) are influenced greatly by social or environmental factors such as exposure to cigarette smoke or access to health care. [78]

The 1997 Children's Defense Fund Yearbook reported that out of nineteen industrialized countries, the United States is ranked eighteenth in infant mortality. [79]

Nationwide, 150,000 infants are born each year with a serious birth defect, the leading cause of infant mortality and childhood disability across the United States. Birth defects are also responsible for 30% of all pediatric hospital admissions.

Though birth defects occur even if mothers receive quality prenatal care, there are preventive strategies that can be beneficial. For example, the risk of having a baby with a neural tube defect can be reduced by nearly 50-70% if all women of childbearing age consumed the daily allowance of folic acid. [80]

F. CHILDHOOD DEATHS

In 1996, there were 197 childhood deaths in Massachusetts in the 1-14 years age range. The leading cause of death for children was unintentional injuries, at a rate of 3.1 for every 100,000 children in this age group. Cancer claimed the lives of 34 children, while motor vehicle accidents caused 15 child deaths. In the 1-14 age range in 1995, there were 24 childhood deaths due to congenital anomalies, such as heart or respiratory anomalies. Fourteen children were victims of homicide, and there were three suicides of children 14 years old and younger. [81]

In 1996, the national child mortality rate for children aged 1-4 years old was 39 per 100,000 children. The national child mortality rate among children aged 5-14 years old was 22 per 100,000 children. These rates are considerably lower than they were in 1980, largely due to declines in deaths from cancer and unintentional injury. [82]

There were 434 deaths in Massachusetts in the 15-24 age range. The leading cause of death was motor vehicle-related injuries, resulting in 116 deaths. There were 72 homicides and 53 suicides in this age range. The homicide rate for males is highest in this age range. In 1996, 33 people aged 15-24 died due to cancer, down 41 from 1995. [83]

The adolescent mortality rate, 84 per 100,000 adolescents, is higher nationwide than that of childhood deaths. Injuries, including homicide, suicide and traffic accident injuries, account for 4 out of 5 adolescent deaths in the United States.

Firearms claimed the lives of 40 Massachusetts children and youth, aged 0-19, including 32 homicides and 8 suicides. Though in 1995, the rate of gun deaths dropped for the first time in eleven years, an average of 14 children a day die from gunfire in the United States. [84]

In 1997, there were 36 alcohol-related traffic fatalities among youth under 21, a 14% decrease per 100,000 youth from 1996. The national improvement rate was just 5% between 1996-1997. In Massachusetts, there were 115 drunk driving related deaths in 1982. Advocates believe that the downward trend is partially due to anti-drunk-driving efforts. [85]

Massachusetts is the only state in the United States that does not have a Child Death Review System. Research from other states confirm that team reviews about child deaths lead to an increased rate of prosecutions for crimes against children and better protection of surviving siblings. Many child advocates and public health professionals believe that a child death review system can be an effective tool in the prevention of child abuse and deaths. [86]

G. LEAD POISONING

Housing conditions are the most frequent cause of childhood lead poisoning, most commonly in the form of ingestion of paint. Lead is now banned from household paint, plumbing systems, and food/drink/gasoline cans. However, children under age 6 who live in housing built before 1960, in a rental unit, in the northeast, or with low household income are more at risk for elevated lead levels. [87] In Massachusetts, an average of 47% of houses were built before 1950, and these "old houses" pose a particular risk for lead poisoning.

In FY97, there were 195,684 children aged 9-48 months screened for lead poisoning, out of a total population of 272,396 children in this age range. This represents 72% of infants and children aged nine months to four years, which is the age range of mandatory universal lead poisoning screening.

There were 446,876 total children between the ages of 6 and 72 months for whom incidence and incidence rates of lead poisoning were being calculated, and 58% of this total population was screened between July 1, 1996- June 30, 1997. Doctors are mandated to evaluate children that may be at a higher risk of lead exposure due to elements such as housing conditions or parental behaviors. The rates of lead poisoning among children who are targeted as "at-risk" should then be calculated, and any necessary treatment should begin, before 9 months and should extend to six years of age, beyond the mandatory screening period.

823 children were confirmed to have elevated blood lead levels, greater than 20 mcg/dL, (micrograms/deciLiter). 331 of these children had a blood lead level over 25 mcg/dL, which is considered lead poisoning. This is a rate of 3.2 per 1,000 screened children who are newly identified children with elevated blood lead levels in FY97. [88]

A recent study found that 5.9% of all children nationwide have blood levels greater than 10 mcg/dL, which places them at risk. The CDC estimates that 1 million children in the US have elevated blood lead levels. [89] However, the recent Federal Interagency Forum on Child and Family Statistics reports that 6% of American children ages 1 to 5 had elevated lead levels between 1988-1994. Between 1976-1980, the percentage was 88%.[90]

This progress can partly be explained by changes in federal and state policies. The Massachusetts Lead Law requires strict control measures or lead paint removal from all homes built before 1978, when children younger than six move in. However, the high cost of lead removal, the scarcity of government assistance for removal, and the higher cost of most newer apartments, poor families are subject to more lead risks at home. [91]

H. CHILDHOOD CANCER

In 1994, there were 240 cases of childhood cancer among Massachusetts children 0-18 years of age. There were 68 cases of Leukemia, 36 cases of cancer of the brain and central nervous system, 21 cases of Hodgkin's Disease, and 20 cases of bone cancer. There also were smaller incidences of childhood cancer of the soft tissues, kidney, thyroid, of Non-Hodgkin's Lymphoma, and many other types of cancer.

From 1982-1994, there were 3419 total cases of childhood cancer in Massachusetts. Of these diagnosed cases of cancer in children 0-18 in the Commonwealth, the leading types of cancer are:

- 22.5% Leukemia
- 16.5% Cancers of the brain and central nervous system
- 10.5% Hodgkin's Disease
- 5.9% Bone Cancer
- 28.3% Other kinds of cancer [92]

I. CHILDHOOD DISEASES

As of 1995, the incidences of many vaccine-preventable diseases have decreased dramatically, largely because of immunization. Several diseases were 97-100% less prevalent than in the year of their maximum presence.

In 1995, there were:

- 438 cases of Pertussis (Whooping Cough)
- 12 cases of Rubella (German Measles)
- 6 cases of Measles
- 1 case each of Mumps, Polio and Hib (Haemophilus influenzae type b) [93]

J. IMMUNIZATION

Immunization is one of the most fundamental public health interventions for children. Since 1967, comprehensive school and day care immunization requirements have contributed to high immunization coverage.

The National Immunization Survey ranked Massachusetts, and the city of Boston, number one nationwide for immunization coverage of children 2 years and under. The state inoculated 87% of children aged 2 and under. [94] 86% of children aged 19 months-35 months in the Commonwealth are fully immunized, though the national average is 77% for this age range. [95]

The Massachusetts Department of Public Health Surveillance Program completed an extensive Immunization Survey in 1997-1998. The survey evaluated immunization rates among children enrolled in Head Start, Licensed Group Daycares, Kindergartens, and Seventh grades.

Of the 9,667 children enrolled in Head Start, including 9,574 who are older than two years of age:

- 99.2% have received 4 doses of DTP (Diphtheria, Tetanus, Pertussis) vaccine
- 99.5% have received 3 doses of Polio vaccine
- 99.6% have received 1 dose MMR (Measles, Mumps, Rubella) vaccine

Of the 128,644 children enrolled in licensed group daycares, including 116,830 children who are older than two years of age:

- 97.3% have received 4 doses of DTP
- 98.1% have received 3 doses of Polio vaccine
- 97.9% have received 1 dose MMR

Of the 85,304 Massachusetts children enrolled in Kindergartens:

- 96.8% have received at least 4 doses of DTP vaccine
- 97.0% have received at least 3 doses of Polio vaccine
- 97.3% have received at least 1 dose of MMR vaccine

Of the 81,172 children enrolled in grade seven in Massachusetts,

- 99.2% have received at least 1 dose of MMR
- 95.7% have received at least 2 doses MMR

However, only 47.76% of seventh graders have received 3 doses of the Hep B vaccine. [96]

Immunization has been proven to be a cost-effective public health program. Research has shown that for every $1 spent on immunizations, ten dollars are saved in subsequent health care costs that are prevented. [97]

In May of 1998, the Massachusetts Public Health Council approved a mandate that all children entering kindergarten and seventh grade in 1999 will have to show proof that they have been vaccinated for chicken pox or have had the disease. Starting in 2005, all students will have to show this proof. OCCS has also made chicken pox vaccination mandatory for children enrolling in child care, which started in August of 1998. State regulations allow for religious or medical exemptions, but not for philosophical or personal reasons. The Commonwealth is the first state in the nation to mandate chicken pox vaccination. [98]

K. ASTHMA

The Massachusetts EOHHS Division of Health Care Finance and Policy reports that in 1996, there were 2,793 hospital admissions of children 0-17, due to asthma. The preventable hospitalization rate was 2.01 per 1,000 children. The hospitalizations are considered avoidable because the conditions, if treated by a primary care physician, would not advance to the point where hospitalization is necessary. [99] Almost one-third of all preventable hospitalizations among children aged 17 and under are asthma related. [100]

Asthma is the most chronic childhood illness, and it claims the lives of hundreds of children in the United States each year. The incidence of asthma has increased 29% in the last decade. The hospitalization rate for asthma is almost three times higher among African-American children than white children.. Poor families are also at a higher risk of illness because asthma is triggered by many factors in substandard housing, including cockroaches, mold, rodents, and dry heat. [101]

L. AIDS

As of August 1998, the DPH AIDS Surveillance Program reports that there have been 246 cases of AIDS (Acquired Immunodeficiency Syndrome) among Massachusetts children aged 19 and under, since the state began keeping records on AIDS cases. 79% of the cases affect children under thirteen years of age. 103 of these children and youth are still alive, but 141 children and youth have succumbed to the disease.

The racial distribution of the total Massachusetts pediatric AIDS cases is: 91 black children, 85 white children, 69 Hispanic children and 1 Asian child. 150 of the childhood AIDS cases involved males. The predominant mode of transmission is from a HIV (Human Immunodeficiency Virus) infected mother.

There are an additional 211 Massachusetts children and adolescents, aged 19 and under, who are infected with HIV. The numbers of these children and youth are almost equal by gender. The modes of exposure to the virus in this population include 90 cases due to

injection drug use, 55 cases of transmission from an HIV-AIDS infected mother, 30 cases due to sexual contact with an injection drug user, and 13 cases of sexual contact with an HIV-AIDS infected person. There was a smaller rate of exposure due to blood transfusions. [102]

The 1997 Youth Risk Behavior Study conducted by the Massachusetts Department of Education found that 93% of students had been taught about AIDS/HIV in school. Slightly less than half have received a presentation by a person who has AIDS or HIV, and 53% have been taught in school how to use a condom.

IX. CHILD AND YOUTH HEALTH STATUS AND BEHAVIOR

A. SEXUAL ACTIVITY

In the 1997 Youth Risk Behavior Study, 45% of Massachusetts high school students surveyed reported ever having had sexual intercourse, and 31% had intercourse within three months of the study. In the Commonwealth, this was a lower percentage than in 1993 and 1995. Among sexually active adolescents, 57% reported condom use, a 5% increase from 1993. [103] Most unintended pregnancies are due to improper contraceptive use or failure to use contraception. The Population Resource Center found that roughly 26% teenagers nationwide experience contraceptive failure in the first year of use. [104]

The 1995 Youth Risk Behavior Survey showed that there was a correlation between alcohol consumption and sexual activity among teens. 25% of sexually experienced students who reported drinking heavily also reported two or more partners in the past three months, in contrast to only 9% of sexually experienced students who did not drink heavily. Three times as many heavy drinking ninth graders are sexually experienced as compared to light or non-drinkers. [105]

B. SEXUALLY TRANSMITTED DISEASES

The Massachusetts Department of Public Health maintains a Surveillance Report on the statewide incidence rates of Sexually Transmitted Diseases (STDs). In 1997, there were 7,993 reported cases of chlamydia among adolescents 15-19, a rate of 631 per 100,000 adolescents. The rate of adolescent chlamydia in 1996 was 585 per 100,000 Massachusetts teens.

Among Massachusetts adolescents aged 15-19, there were 2,383 reported cases of gonorrhea in 1997. This amounts to a rate of 131 per 100,000. Though this is just a slight decrease from 1996, it is a considerably lower rate than the 1989 incidence rate of 371 per 100,000. In 1997, there were 89 cases of adolescents with syphilis, at a rate of 3 per 100,000 adolescents. There has also been a downward trend with this STD, down from a rate of 23 per 100,000 teens in 1990. [106]

The 1996 Massachusetts Adolescent STD Report showed that adolescents and young adults (10 to 24 years old) are at a higher risk for acquiring an STD, largely because they are more likely to choose multiple or risky partners and are more likely to have unprotected intercourse. In addition, the higher prevalence of STD among adolescents reflects multiple barriers to quality prevention services, including lack of insurance or transportation, and concerns about confidentiality.

The Centers for Disease Control and Prevention estimate that 12 million people annually acquire a sexually transmitted disease (STD) and that two-thirds of these infections occur in persons under the age of 25. [107]

C. TEEN PREGNANCY

The teen birth rate in Massachusetts in 1996 was 32.6 per 1,000 young women, between the ages of 15-19. This is down from 33 per 1,000 adolescents in 1995, and is about half the national average of 54.7 per 1,000. The Department of Public Health notes that teen pregnancy prevention programs, after school programs, health education and family planning initiatives in Massachusetts have helped contribute to teens delaying sexual activity and utilizing contraception. [108]

In Massachusetts, there were 5,849 infants born to mothers under the age of 20 in 1996, a decline of 258 births from 1995. Since the peak in 1989, the number of teen births has declined by 24.4%. 7.9% of all Massachusetts births were to teen mothers, well below the national percentage of 12.9%.

The percentage of adolescents giving birth who are unmarried is 90.3%, a steady rise from 1980 when the percentage was 56.9%. However, the joint DPH and DOR paternity acknowledgment program has led to one of the highest percentages of paternity acknowledgment in the nation. 62.8% of all births to unmarried adolescent mothers included the infant's father acknowledging paternity in the birth hospital.

The Racial and ethnicity distribution among teen births in Massachusetts in 1996 was:

- 50.5% were to white, non-Hispanic mothers
- 29.4% were to Hispanic mothers
- 13.8% were to black, non-Hispanic mothers
- 2.8% were to Asian mothers [109]

In the FY98 and FY99 budgets, the Massachusetts legislature appropriated funds for Healthy Families, a pilot Newborn Home Visiting program for all first-time mothers under the age of nineteen in the Commonwealth. Healthy Families, which began in the Winter of 1997, has served over 1,000 young families statewide. Early evaluations from program participants have shown a 93% rate of great satisfaction with Healthy Families and with the home visitors. [110]

Research in other states has shown that home visiting programs educate and support families, reduce child abuse and neglect and promote better child health. Other potential benefits for the young families are reduction in subsequent unplanned pregnancies, as well as increased capacity for economic independence and school completion. [111]

D. GAY, LESBIAN AND BISEXUAL YOUTH

The 1995 Massachusetts Youth Risk Behavior Survey found that 2.6% of high school females and 2.5% of high school males reported having sexual contact with members of the same sex. 4.4% of all high school students, and 6.4% of sexually experienced public school students, have had sexual contact with a member of the same sex and/or describe themselves as gay, lesbian or bisexual.

This group who described themselves as gay, lesbian, or bisexual and/or have had same sex sexual contact were:

- four times more likely to have attempted suicide
- five times more likely to miss school because of feeling unsafe
- nearly five times more likely to have used cocaine
- nearly twice as likely to have been in a physical fight
- twice as likely to have been threatened/injured with weapon at school [112]

The Massachusetts Governor's Commission on Gay and Lesbian Youth, the first of its kind in the nation, was initiated by then-Governor William Weld. The Gay and Lesbian Rights bill was also passed in the Commonwealth to offer full legal protection to gay teenagers, a landmark piece of legislation which other states have emulated.

At the national level, 9% of America's 15 million high school students described themselves as gay, lesbian, bisexual or "questioning". 33% of an estimated 5,000 teen suicides annually are gay teenagers. Some studies have shown that 25% of gay teenagers in the United States leave home and drop-out of school because of intolerance. [113]

E. TOBACCO USE

The 1997 Massachusetts Department of Education Youth Risk Behavior survey found that the rates of recent cigarette smoking among high school students had declined slightly to 34.4%, from 35.7% in 1995. 69.1% of surveyed high school students in the Commonwealth reported that they had ever tried cigarettes, and 14.5% said that they smoke daily. Nearly one in five students smoked cigarettes on school property. [114]

The Department of Public Health study of Adolescent Tobacco Use in Massachusetts 1984-1996 evaluates trends of teen tobacco use. The average age for smoking a first whole cigarette in grades 7-12 was 12.2 years of age. In 1996, lifetime cigarette use (those who have ever tried cigarettes) in grades 7-8 was 42%, down from 45% in the Tobacco Study in 1993. The rate of current use in these grades was 21%, just slightly smaller than the rate in 1993.

Lifetime use of smokeless tobacco (chewing tobacco or snuff) in grades 7-8 dropped from 16% in 1993 to 9% in 1996, while current use dropped 6% to 2%. For high school students, lifetime use of smokeless tobacco declined from 25% to 20% in 1996, and current use was at 6%, down from 9%. [115] 10% of male students, and nearly one in eight white male students, were current users of smokeless tobacco. [116]

The National Institute on Drug Abuse reports that nationwide, the percentage of eighth, tenth and twelfth graders who reported smoking cigarettes daily has increased between 1992 and 1997. In 1997, 25% of students in their senior year of high school reported smoking daily in the month before the survey. [117]

The US Centers for Chronic Disease Prevention and Health Promotion reports that 3,000 of this country's children and youth begin smoking every day, comprising 90% of the population of new smokers. Children and teens purchase 2.6 million packs of cigarettes per day. [118]

There are long term health consequences and increased health care costs nationwide due to smoking-related diseases. It is estimated that more than 5 million of today's underage smokers will die of tobacco-related illnesses. [119] Children and youth are also at risk due to tobacco use by parents. The Archives of Pediatrics and Adolescent Medicine reports that 6,200 US children die annually due to environmental tobacco smoke-related deaths, including SIDS, burns, low birthweight and respiratory problems. [120]

F. SUBSTANCE USE/CHEMICAL DEPENDENCY

The 1996 DPH Adolescent Substance Abuse Survey showed that there is a rising trend in drug use, particularly for high school students in Massachusetts, and particularly increased use of marijuana in all grade levels. Marijuana use among high schoolers in the Commonwealth rose sharply, with lifetime use increasing to 52% from 38%, and current use in grades 9-12 rising to 33% from 23%. In Massachusetts, 20% of seventh and eighth grade students reported that they had ever used marijuana, up from 14% just 3 years earlier. 10% of seventh and eighth graders also said they were current users of marijuana, an increase from 7% in 1993.

The 15% of youth in grades 9-12 who reported lifetime use of psychedelic drugs was a 7% increase from 1993, and current use by high schoolers was 5%. The lifetime and current use of narcotics by high schoolers also increased slightly, to 8% and 3%. The number of high schoolers who reported ever or currently using amphetamines, tranquilizers, and barbituates all increased, while rates of cocaine, steroids and inhalants use were stable.

24% of students reported that they had been high on marijuana or other drugs at school in the past year, a 10% increase from 1993. 24% of students said that they had been supplied with drugs at school, and 27% of high schoolers reported driving after using marijuana.

4% of seventh and eighth grade students in Massachusetts reported ever having used cocaine, and 7% had used inhalants at least once. Females in this age range had approximately 7% increases in their use of marijuana and inhalants, though males experienced level or decreased rates of drug use.

The 1996 Massachusetts study included sixth grade students for the first time. Though their rate is lower than seventh graders, 22% of sixth graders reported that they have used drugs other than alcohol and tobacco. The drug that had most commonly been tried was inhalants, at 14%, followed by tranquilizers and marijuana at 6% each. [121]

A national study shows that age 12 is a key time for drug abuse prevention. A recent survey from Columbia University's National Center on Addiction and Substance Abuse found that three times as many youth know how to buy marijuana or know someone who has used drugs at age thirteen than at age twelve. The same study showed that teenagers, for the fourth consecutive year, said drugs were the most important problem they face. 78% reported that the amount of drugs that are used and sold at their schools continues to rise. [122]

At a national level, 26% of high school seniors, 23% of tenth graders, and 13% of eighth graders reported using illicit drugs in the month prior to the National Institute of Drug Abuse survey.

Between 1992-1996, drug use at each grade level increased substantially:

- 26% for 12th graders, up from 14%
- 23% for 10th graders, up from 11%
- 15% for 8th graders, up from 7%

Illicit drug use among children and adolescents has been shown to have immediate long-term health and social consequences. Individual drugs have specific effects, such as the pulmonary and cognitive damage caused by marijuana use. [123]

G. ALCOHOL

The 1996 Massachusetts Department of Public Health Substance Abuse survey showed that 71% of students in grades 7-8 and 86% of high school students reported drinking at least once in their lifetime. 27% of seventh and eighth graders and 54% of high school students reported drinking alcohol in the month prior to the survey. 26% of surveyed youth in grades 7-12 reported heavy drinking, (five or more drinks in a row), in the two weeks prior to the survey. 37% of twelfth graders reported binge drinking.

15% of high school students reported being high on alcohol while in school, a 5% increase from the year before. 26% of students in grades 9-12 reported driving after drinking, and 11% drove after heavy drinking.

The 1997 Massachusetts Youth Risk Behavior Survey showed that alcohol use is associated with illegal drug use, fighting, suicide attempts, and dating violence.

At the national level in 1997, one in three twelfth graders, one in four tenth graders, and one in ten eighth graders reported heavy drinking in the two weeks prior to the survey. Alcohol, though illegal for those under 21, is the most commonly used psychoactive substance among adolescents. [124]

H. MENTAL HEALTH

The Massachusetts Department of Mental Health estimates that there are 71,082 emotionally disturbed children in Massachusetts. This population includes youth who currently or at any time during the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria within DSM III-R (Diagnostic and Statistical Manual, Edition 3) and that resulted in considerable interference in social functioning.

Currently, approximately five million children under 18 in the United States have a mental illness that is not being treated, even though many have over a 60% treatment success rate. 20% of children and adolescents between ages 0-17 have a diagnosable mental, emotional, or behavioral disorder. [125]

Research has shown that 48% of children with serious emotional disturbance (sed) never graduate from high school, as opposed to 24% of all high school students. 20% of students with sed are arrested at least once before they leave school, in contrast to 20% of students with other disabilities, and have lower grades than any other category of students. [126]

It is estimated that 150,000 youth involved in the juvenile justice system each year meet the diagnostic criteria for at least one mental disorder, and research has shown that juvenile justice services are inadequate to meet their needs. [127]

I. SUICIDE

The Massachusetts Department of Public Health reports that in 1996, 3 children under the age of 14 committed suicide. There were 53 suicides in the 15-24 year old age group in the Commonwealth. Suicide is the third leading cause of death for young adults in this age range, but the 1996 total is a decrease of 21 suicide deaths from 1995. [128]

In 1997, 10% of Massachusetts public high school students, or approximately 24,000 adolescents, attempted suicide. One in four high school students reported that they had seriously considered suicide in the year before the survey.

The Children's Defense Fund reports that nationwide there were 1,450 firearm suicides by adolescents in 1995. [129] In United States, the overall firearm suicide rate rose from 5 per 100,000 15-19 year olds in 1983 to 7 per 100,000 in 1993. [130]

J. VIOLENCE AND WEAPONS

In 1995, there were 3 homicides of children under 14 and 72 homicides in the 15-24 year old age range in Massachusetts. Homicide is the second leading cause of death in the Commonwealth for the adolescent age group. [131]

According to the National Center of Health Statistics, 5,000 children nationwide die each year of gun-related homicides, suicides, and unintentional injuries. [132] A recent Johns Hopkins School of Public Health study showed that 88% of survey respondents favored laws to make new guns childproof, including 80% of gunowners. Between 83-95% of

respondents, including seven out of ten gun owners, favor a ban on gun sales to people convicted of domestic violence, assault, drunk and disorderly conduct, or menacing someone with a gun.

The Physicians for Social Responsibility reports that gun violence costs $20 billion per year nationwide, including medical costs and lost productivity. [133]

K. JUVENILE CRIME

In FY98, there were 4,684 detention admissions by the Massachusetts Department of Youth Services, an increase of 50 from FY97. Detention admissions in the first half of calendar year 1998 were at a 13.2% higher average than in the five year period of 1993-1997.

DYS reports that there were 779 new commitments in the first half of calendar year 1998, an increase of 9.1% from the same period in 1997. Thus, it is expected that there will be approximately 1,521 new commitments in 1998, an increase of 127 from one year earlier.

As of July 1, 1998, the total committed caseload was 3,056 youth, and 87.4% of committed youth were male. This committed population represents a 93.5% increase since January 2, 1992. There were 233 pre-trial youths in the DYS system, 186 males and 47 females. [134]

The Massachusetts rate of juvenile violent crimes arrests has worsened by 101% since 1985, and the Commonwealth was ranked 41 nationwide in this category in 1995. However, the national juvenile arrest rates for violent crimes, (such as murder, rape, robbery and aggravated assault) dropped by more than 12% in 1996, a decline for the second year in a row. [135]

The National Crime Victimization Survey's School Crime supplement showed that 14.6% of students in 1995 reported any victimization, (violent or property), at school. This marked only a .1% increase from the last survey in 1989. However, the reports of street gang presence in the schools nearly doubled in this time period, from 15.3% to 28.4%. [136]

L. GIRLS AND JUVENILE JUSTICE

Since 1992, the population of committed females in Massachusetts DYS has more than tripled, an increase of 208.8%, since 1992. The committed caseload of females increased 22.5% in FY98. [137] At the national level, the number of juvenile females arrested for Violent Crime Index offenses increased 25% between 1992-1996, while male juveniles

experienced no increase in this category of arrests. Juvenile female arrests for Property Crime Index offenses increased 21% in this time period, while juvenile male arrests in this category decreased 4%. [138]

Nationally, females accounted for 57% of youth arrests for running away from home, 36% for offenses against family and children, and 55% for prostitution. Females were also responsible for 6% of juvenile arrests for murder and non-negligent manslaughter, 9% for robbery, 31% for larceny-theft, 14% for motor-vehicle theft and 19% for aggravated assault. [139]

Many suggest that the unique characteristics of female offenders require specialized aspects in their treatment, including medical and social services. A 1990 American Correctional Association study of girls in juvenile facilities reported that 61% were physically abused in the past, 54% had been sexually abused and 54% had attempted suicide at least once. More than half had used drugs on a regular basis and were more sexually active than other girls in their age range. [140]

M. YOUTH EMPLOYMENT

The Bureau of Labor Statistics estimates that an average of 20,000 youth in Massachusetts were unemployed in Massachusetts in 1996. During the school year, approximately two-fifths of the nation's 16 and 17 year-old high school students are working or looking for work; this proportion increases to more than one-half during the summer. [141]

In 1995, 7% of Massachusetts youth ages 16-19 who are not in school are also not working. The national rate in this vulnerable category was 9%, slightly lower than the rate of 11% in 1985. [142]

In 1996, the national unemployment rate for 16-19-year-olds fell to 16.7%, from 17.3% in 1995. The national unemployment rate for 20-24 year olds is 9.3%. The unemployment rate of those without a high school diploma rises to 22.1%, and it is 12.1% for high school graduates between 16 and 24 years of age. Only 5.4% of 16-24 year olds who had completed four or more years of college were unemployed. [143]

N. YOUTH SERVICE

The Commonwealth has been a leader in youth service nationwide. The Massachusetts Service Alliance (MSA), which was established in 1991, was one of the first state commissions in the United States devoted to community service.

The national AmeriCorps program was based on the Massachusetts service programs such as City Year.

In Massachusetts, the past year marked record youth participation in service programs statewide. In the 1997-1998 program year, 172,345 youth participated in youth service programs sponsored by the MSA. This was a marked increase from the 1996-1997 participant population of 56,347. There were also approximately 290,000 youth who served in youth programs such as 4-H, Girl and Boy Scouts.

There are currently 929 youth serving in the AmeriCorps USA programs in Massachusetts, providing over 1,000,000 hours of community service. An additional 120 youth are in the AmeriCorps VISTA program. AmeriCorps team members make a year-long commitment to a wide array of service projects, ranging from education to public safety.

The number of youth who participated in in-school based youth service, kindergarten-12th grade, jumped from 52,889 to 169,000. There were an additional 1,483 youth in service in community-based after school programs. 813 college students were involved in youth service, in programs such as Mass. Campus Contact. This marked approximately a 75% jump from the 1996-97 program year. [144]

As well as bringing positive changes to the communities themselves, youth service is being widely recognized as a positive trend in youth development. A 1996 evaluation by Abt Associates found youth corps programs, such as AmeriCorps and City Year, to be cost-effective and to have strikingly positive effects on the skills and leadership development of participants. [145]

O. CHINS (Children in Need of Services) Petitions

The Children in Need of Services (CHINS) Statute was enacted in Massachusetts in 1973 to create a new category of status offenders (stubborn child, runaway and truant), to make status offenses noncriminal, and to eliminate secure detention of status offenders with juvenile delinquents in the DYS system. Under the CHINS statute, the authority over status offenders was placed with the Department of Social Services. [146]

In FY97, there were 1,435 children in substitute care placement who were CHINS Referrals to DSS. CHINS Referrals accounted for 17% of both first time and repeat entrants. However, only 9% of consumers who remained in care were CHINS referrals and 16% of consumers who left DSS care in FY97 had been CHINS referrals. As of July 1997, 44% of CHINS intakes had been in care six months or less, in comparison to 20% of maltreatment intakes and 25% of voluntary intakes. These statistics indicate that CHINS referrals are often more short-term placements. [147]

P. CHILD ABUSE

In 1996, there were 28,888 supported investigations of maltreatment in the Commonwealth. There has been a 21% increase in children with supported abuse investigations from FY83 to FY97.

Child maltreatment is the major factor contributing to the opening of cases with DSS. 78% of Hispanic children, 76% of black children and 68% of white children in placement as of July 1997 had their cases opened because of maltreatment investigations.

In 1995, approximately 3 million children nationwide were reported to child protective services as possible victims of child abuse and neglect. 52% of reports were for neglect, 25% concerned physical abuse and the others were for sexual or emotional abuse. Nearly 1 million children were identified as victims of abuse and neglect. [148]

Q. DOMESTIC VIOLENCE

In 1995, the American Humane Association reported that research about domestic violence has shown that between one-third and one half of children exposed to domestic violence are direct victims. Studies show that the number of children who witness domestic abuse is even higher, as high as 87% in some reports.

In Massachusetts, child protection workers are trained to recognize and address domestic violence. [149]

Children in homes where domestic violence occurs are abused and neglected at a rate of fifteen times higher than the national average. 68-87% of partner abuse incidents are witnessed by children, by as many as 43,000 Massachusetts children annually. Exposure to domestic violence has been shown to make children more at risk of serious emotional difficulties, symptoms of regression and trauma, substance abuse, and more at risk of being violent in their own future relationships. [150]

The Massachusetts Legislature unanimously passed Chapter 179 of the Acts of 1998, relative to protecting children from domestic violence in custody and visitation proceedings. The law creates a rebuttable presumption that parents who perpetuate a "pattern or serious incidence" of abuse against their spouses or children will not be granted custody of the children in divorce, separation and paternity proceedings. There are also protections for supervised visitation with the abusive parent. [151]

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